Delivering Dementia-Capable Age-Friendly Care

A 4Ms RESOURCE FOR HEALTHCARE PROVIDERS

A JOINT COLLABORATION

HANYS® Always There for Healthcare SINCE 1925

ALZHEIMER'S® ASSOCIATION

Practical tools and evidence-based strategies

ABOUT HANYS

Established in 1925, the Healthcare Association of New York State advances the health of individuals and communities by providing leadership, representation and service to not-for-profit and public hospitals, health systems, nursing homes and other healthcare organizations across New York state.

HANYS members serve the healthcare needs of nearly 20 million New Yorkers and visitors from around the world, while playing a vital role in their local communities and economies. HANYS engages actively with policymakers, agencies and the media in both Albany and Washington, D.C., often in collaboration with community and association partners, to ensure that New Yorkers' healthcare needs are met.

Beyond advocacy, HANYS provides premiere educational programs, expert data analysis, quality improvement initiatives and business services that strengthen its members and partners.

From 2020 – 2025, HANYS led a statewide Age-Friendly Health Systems Action Community, supporting more than 200 hospitals, federally qualified health centers, nursing homes and home health agencies in achieving Age-Friendly recognition through the Institute for Healthcare Improvement. By embedding the 4Ms framework (What Matters, Medication, Mentation and Mobility) into everyday practice, HANYS has helped organizations reduce avoidable hospitalizations, improve safety and enhance patient and family experience.

This combined legacy of statewide leadership and on-the-ground programmatic support uniquely positions HANYS as a trusted partner in advancing Age-Friendly, dementia-capable care across the care continuum.

ABOUT THE ALZHEIMER'S ASSOCIATION

The Alzheimer's Association is the leading voluntary health organization dedicated to Alzheimer's care, support and research. Its mission is to end Alzheimer's disease and related dementias by advancing treatment, prevention and, ultimately, a cure. The association is the largest nonprofit funder of Alzheimer's research and a powerful voice in advocacy, championing critical research and care initiatives at both the state and federal levels.

The Alzheimer's Association Health Systems team partners with health system leaders nationwide to advance evidence-informed dementia care. This program spreads best practices and accreditation models, while providing patient resources and continuing medical education on prevention, diagnosis, treatment and care of ADRD. Additionally, through ALZPro, the Association's integrated hub for professional resources, health systems can access clinical guidelines, research, data platforms, care resources, continuing education, and implementation tools in one trusted location. Many continuing education opportunities are available for physicians, radiologists, neurologists, nurses, advanced practice providers, physician assistants, psychiatrists, social workers, pharmacists and other clinicians. Together, these efforts ensure that communities across the country have access to person- and family-centered, high-quality dementia care grounded in the best available evidence.

The Alzheimer's Association 24/7 Helpline provides free, reliable information, education, referrals, crisis assistance and support to individuals living with the disease, their families, healthcare professionals and the public. Call 800.272.3900 or visit alz.org/helpline for more information.

OUR PARTNERSHIP

HANYS and the Alzheimer's Association, New York State Coalition have partnered to bring Alzheimer's disease and related dementias-capable care into Age-Friendly Health Systems. Together, we are bridging the Age-Friendly 4Ms framework with ADRD-specific practices so that providers can better recognize, manage and support individuals living with ADRD and their care partners.

This partnership leverages HANYS' statewide leadership in health system transformation and the Alzheimer's Association, New York State Coalition's deep expertise in ADRD care, education and support. This resource is designed to help providers across care settings apply Age-Friendly and ADRD-capable principles in practice, ensuring that care for older adults is person-centered, evidence-informed and responsive to both medical and social needs.

IN THIS GUIDE

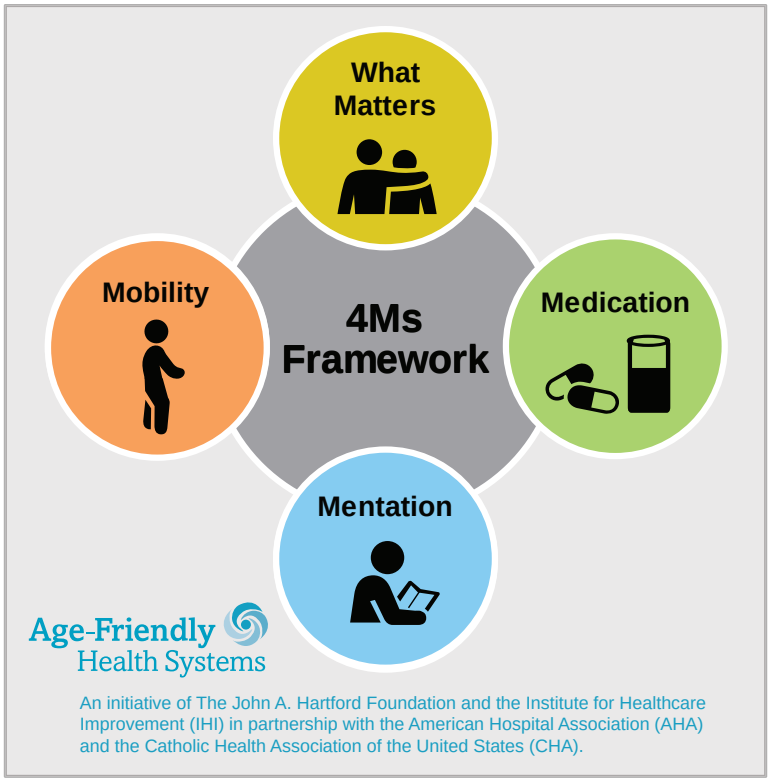
WHAT IS AGE-FRIENDLY 4Ms CARE

The Institute for Healthcare Improvement launched the Age-Friendly Health Systems initiative in 2017 in partnership with the John A. Hartford Foundation, American Hospital Association and Catholic Health Association of the United States. The movement was created to ensure that every older adult receives care that is evidence-based, safe and aligned with their goals and preferences, regardless of where they receive care.

The 4Ms framework provides a simple, scalable structure to organize care:

- **What Matters:** Know and align care with an older adult's specific health outcome goals and care preferences.
- **Medication:** Use age-appropriate medications that do not interfere with mentation or mobility and that support What Matters.
- **Mentation:** Prevent, identify, treat and manage dementia, depression and delirium.
- **Mobility:** Ensure that older adults move safely every day to maintain function and independence.

The Age-Friendly Health Systems movement has spread rapidly since its launch, with more than 5,000 care settings nationwide adopting the 4Ms standard of care. These efforts reduce harm, improve outcomes and promote person-centered, equitable care across settings and transitions.



WHY FOCUS ON ALZHEIMER'S DISEASE AND RELATED DEMENTIAS?

Dementia is a general term for decline in cognitive function or ability that impacts activities of daily living. Alzheimer's disease is the most common form of dementia. It is a progressive neurological condition that impairs memory, thinking and judgment. Alzheimer's disease affects more than seven million people in the U.S., with numbers projected to rise significantly as the population of those living longer increases. Other forms of dementia, such as Lewy body, vascular and frontotemporal dementia, share similar cognitive and functional impacts, yet have different etiologies or root causes, some of which can be reversed.

Over 95% of people with ADRD are living with another chronic condition such as heart disease, diabetes or stroke. This complicates the management of chronic disease and can result in poorer health outcomes and increased healthcare costs.

Older adults with ADRD often experience:

- difficulty with communication, which complicates the sharing of goals and preferences;
- increased risk of falls, delirium, medication errors and emergency room visits;
- higher rates of hospital admissions and longer lengths of stay; and
- greater reliance on caregivers for daily function and decision-making.

These challenges can interfere with every component of the 4Ms, making it critical for providers to adjust their approach. Despite this need, there has been a lack of structured guidance on how to deliver 4Ms care that is responsive to the realities of ADRD across care settings.

WHY THIS GUIDE EXISTS

This resource was created to help healthcare providers deliver high-quality, Age-Friendly care to older adults living with Alzheimer's disease and related dementias. While the 4Ms Framework (What Matters, Medication, Mentation and Mobility) is a cornerstone of Age-Friendly Health Systems, people living with ADRD face unique challenges that demand a tailored approach in each of these domains.

PURPOSE OF THIS RESOURCE

This resource offers clear, specific matrices that outline how ADRD intersects with each of the 4Ms in ambulatory, hospital and long-term care environments. Each matrix includes:

- **ADRD and the 4Ms:** How ADRD change or complicate each of the 4Ms.
- **Clinical impact:** The benefits for patient safety, well-being and outcomes if ADRD-specific needs are addressed.
- **Clinical tools:** Validated tools and assessments for screening, monitoring and planning.
- **Provider actions:** Practical, evidence-based steps to improve care, including both high-evidence interventions and low-lift strategies for under-resourced settings.

Each matrix is designed as a one-page reference sheet for clinicians, nurses, pharmacists, care coordinators and interdisciplinary team members.

To deepen understanding of how ADRD intersects with the 4Ms framework, this resource incorporates dementia care journeys. These narratives follow individuals and caregivers through different stages of illness. The stories illustrate in practical terms how social supports, care coordination and clinical decision-making directly influence outcomes for people living with ADRD. By tracing both challenges and successes, the narratives highlight critical gaps in care delivery and opportunities to improve outcomes when the 4Ms are applied consistently and effectively.

In addition, this resource includes appendices with expanded clinical guidance, implementation tools and a curated collection of more than 70 peer-reviewed studies, toolkits and provider templates.

Together, these materials provide clinicians and health system leaders with practical, evidence-based strategies to strengthen ADRD care while advancing Age-Friendly practice.

HOW TO USE THIS GUIDE

This guide is designed to help interdisciplinary healthcare teams recognize, respond to and reduce the risks ADRDs pose to Age-Friendly care. Whether used in daily practice, team huddles, training sessions or quality improvement projects, it serves as both a clinical reference and an action-oriented planning tool.

1 Begin with the care setting most relevant to your role or team.

- This guide includes one-page matrices outlining how ADRD uniquely affects the 4Ms in three care settings: ambulatory, hospital and long-term care. Each matrix highlights the information most relevant to its care setting, but the others may also offer you valuable insights. We encourage you to review them all.
- These easy-to-navigate matrices can be printed, distributed at meetings and/or added to provider resource kits.

For each M, you'll find:

- **ADRD and the 4Ms** – How ADRD changes or complicates care in this domain.
- **Clinical impact** – How these changes influence real-world care delivery if addressed properly.
- **Clinical tools** – Recommended screening instruments, assessments or frameworks.
- **Provider actions** – Practical steps you can take, ranging from high-evidence strategies to low-lift interventions for under-resourced teams.

2 Use this guide for both immediate care planning and long-term improvement.

- Reference the matrices during care conferences, rounds, medication reviews, discharge planning or case reviews.
- Integrate the guide into quality improvement initiatives focused on dementia-capable or Age-Friendly care.
- Identify gaps in documentation or alignment across the 4Ms and use suggested tools or actions to close them.

3 Link to evidence and deepen your understanding.

- Many bullet points in the matrices are annotated with a superscript that corresponds to the resource numbers listed in Appendix C.
- Appendix C provides a list of evidence-based citations, including clinical tools, validated studies and practice recommendations. These citations include two- to three-sentence summaries of key clinical takeaways, assisting you to identify those most helpful resources for building buy-in and shared understanding.

4 Apply the dementia care journeys (i.e., practical narrative tools) to real-world systems change.

- The three narrative care journeys depict fictional patients living with ADRD and their care partners, showing both typical (often fragmented) system responses and an Age-Friendly, dementia-capable alternative.
- Each scenario highlights multiple touchpoints across settings, demonstrating how gaps in recognizing or applying the 4Ms can lead to preventable harm and how embedding the 4Ms can improve outcomes.
- Along with the teaching points, providers can use these tools for clinical education, role-play or system redesign, helping teams to reflect on:
  - how current workflows align with or deviate from dementia-capable, Age-Friendly principles;
  - where patients and caregivers encounter stress, gaps or delays in care; and
  - how earlier recognition, better coordination and integration of the 4Ms could prevent crisis points and support safer, more person-centered trajectories.

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APPLYING THE 4Ms:
DEMENTIA-CAPABLE PRACTICE MATRICES

4M Domain	ADRD and the 4Ms	Clinical impact	Clinical tools	Provider actions
What Matters	• Decision-making capacity may fluctuate, so values/preferences can be hard to express without support.[1] • There may be difficulty engaging in care planning without caregiver input.[2]	• Aligning care with the older adult's goals improves their psychological well-being and satisfaction with care. • Early, ADRD-specific advance care planning can also reduce unwanted high-intensity interventions and emergency hospitalizations in late stages.[3] • Goals-aligned care supports continuity during transitions (ambulatory – hospital – long-term care).	• Get to Know Me form (preferences, history and what matters most).[4] • Conversation Project Dementia Starter Guide (structured prompts).[5] • Caregiver-reported goals guides (proxy input when communication is limited).[6] • Advance care planning forms (e.g., healthcare proxy, advance directive, physician orders for life-sustaining treatment).[7]	• Ask patient directly: "What matters most to you today?" • Hold up or show a visual prompt (photo, word list) to help patient with mild to moderate dementia express goals.[8] • If the patient cannot articulate preferences, involve the caregiver or proxy to honor previously expressed values. • Document at least one concrete priority in the EHR (e.g., "wants to attend church weekly," "prefers staying at home"). • Revisit goals at every major change (e.g., new diagnosis, hospitalization, functional decline).
Mentation	• Early symptoms are often misattributed to normal aging. • Individuals are at increased risk for delirium during acute illness, surgery or medication changes. • Depression is common and may mimic worsening cognitive decline.[9]	• Early detection enables proactive care planning and referral to specialists.[10] • Managing depression improves both mood and cognition, enhancing daily functioning. • Preventing and recognizing delirium preserves baseline function and independence. • Ongoing cognitive tracking supports timely intervention and caregiver preparation.	• Ascertain Dementia 8 if non-verbal (3-min. quick screen at annual wellness visit).[11] • St. Louis University Mental Status (per Alzheimer's Association Clinical Practice Guideline).[11] • Functional Assessment Screening Tool scale (stage dementia progression).[12] • PHQ-9 or Cornell Scale (depression in dementia).[13] • CAM (for acute visits).[14] • Zarit Burden Interview (caregiver stress check).[15]	• Assess or evaluate all patients ages 65+ annually and document results in the EHR with a staging note (e.g., "MCI, Mild AD").[16] • Rule out reversible issues: order labs (e.g., B12/thyroid-stimulating hormone), review medications and ask about sleep. • Educate the caregiver on disease trajectory and safety planning (e.g., wandering, driving, financial oversight). • Counsel caregivers on delirium prevention before surgery/illness (e.g., glasses, hydration, sleep/wake routine). • Provide a referral sheet for a memory café/adult day program.
Mobility	• ADRD accelerates gait instability and reduces judgment about mobility aids. • Fear of falling is prominent, leading to activity avoidance and further deconditioning.[17] • Caregivers may unintentionally over-restrict mobility out of safety concerns.	• Routine movement preserves strength, balance and independence. • Exercise and PT reduce falls and agitation and improve sleep. • Early interventions (e.g., Timed Up & Go, balance classes, home safety changes) delay functional decline.[18] • Supporting safe mobility prevents hospitalizations that worsen cognition.	• Timed Up & Go test (fall risk in clinic).[19] • Performance Oriented Mobility Assessment.[20] • STEADI Fall Risk Toolkit (CDC, outpatient-specific).[21] • Home safety checklists (OT-led or caregiver-administered).[22] • GPS/Safe Return enrollment for wanderers.[23] • Community balance programs (e.g., Matter of Balance).[18]	• Ask "Have you fallen or almost fallen since your last visit?" and log the response. • Observe gait in clinic (stand, walk 10 feet, turn). If unsteady, order PT. • Show caregiver how to assist with walking safely (arm support, clear path).[24] • Prescribe one meaningful daily walking goal (e.g., "walk driveway length to mailbox with caregiver once/day"). • If there is a wandering risk, demonstrate use of door alarms or the Safe Return bracelet.
Medication	• ADRD can lead to nonadherence due to forgetfulness/confusion.[25] • Polypharmacy and certain high-risk medications (sedatives) can be harmful to cognition if not carefully monitored. • Drugs with anticholinergic activity (e.g., diphenhydramine, oxybutynin, amitriptyline, scopolamine) have also been shown to increase risk of dementia.	• Deprescribing inappropriate medications improves clarity, reduces falls and slows decline. • Simplified regimens and caregiver education improve adherence. • Avoiding deliriogenic medications reduces ER visits and rehospitalizations.[26]	• Brown bag review templates (caregiver brings all medications).[27] • Beers Criteria (flag high-risk medications for cognition/mobility).[28] • STOPP/START (geriatric prescribing/deprescribing).[29] • Anticholinergic Burden Calculator (quantify cognitive risk load).[30] • Medication charts/pictograms (color-coded, taped to fridge/pillbox).[31] • Cholinesterase inhibitors/memantine: benefit review guides.[32]	• Have the caregiver bring in all pill bottles ("brown bag review"). • Highlight/flag high-risk medications (e.g., anticholinergics for bladder, benzodiazepines for sleep). • Simplify: consolidate to once-daily dosing or blister packs; ask caregiver to set pillbox weekly. • Provide pictorial or color-coded medication charts (taped to fridge/pill box) for patients with moderate dementia; teach caregivers how to use them.[33] • If antipsychotics are considered, document failed non-drug attempts (music, activity) before prescribing.

HOSPITAL CARE

4M Domain	ADRD and the 4Ms	Clinical impact	Clinical tools	Provider actions
What Matters	• Hospitalization can disorient and confuse patients with dementia.[34] • Communication barriers limit understanding of preferences, especially during acute illness.[35]	• Goal-concordant care reduces delirium, stress and length of stay. • The risk of receiving non-beneficial or unwanted interventions declines.[36]	• Bedside preference boards (preferred name, routines, calming items).[37] • Get to Know Me guide (preferences, history and what matters most).[5] • "What Matters" admission huddles/checklists.[38] • Structured goals-of-care forms (include POLST/advance directives).[7]	• On admission, ask the caregiver, "What routines or comforts help calm your loved one?" Record 2-3 in the chart and on the bedside whiteboard. • Hold an early interprofessional care conference to align care intensity. • Flag priorities in the EHR and during daily huddles (e.g., "comfort focus," "avoid ICU").[39]
Mentation	• Hospital environments often exacerbate cognitive symptoms. • There is a high risk of delirium from infection, medications and sleep disruption.[40]	• Daily delirium prevention lowers length of stay, complications and readmissions. • Optimized mentation supports the return to baseline after discharge.[41]	• CAM (every shift in dementia patients).[14] • CAM-ICU/3D-CAM for ICU or rapid detection.[14] • PAINAD scale (pain in advanced dementia).[42] • Sleep/wake hygiene checklists (night/day orientation cues).[43] • HELP Program toolkit (delirium prevention bundle).[43]	• Bundle delirium prevention into standard orders: sensory aids, day-night schedule, minimized room changes. • Screen every shift with CAM; document in the EHR. • Ensure eyeglasses/hearing aids/familiar items are always available; check daily. • Teach staff a reorientation script (state name, date, place, plan). • Involve family or volunteers for support.[44] • Investigate sudden changes: infection, constipation, medication side-effects. • Use non-drug calming first (e.g., photos, music, familiar blankets); avoid restraints. • Document delirium episodes and communicate at discharge for follow-up. • Incorporate a Delirium Superimposed on Dementia Algorithm into the EHR.
Mobility	• Immobility leads to deconditioning and increases fall risk.[45] • Dementia-related apathy or fear may limit engagement in PT. • Staff may restrict movement, worsening decline. • Bedrest accelerates delirium and functional loss.	• Early ambulation prevents delirium, preserves independence and shortens length of stay. • Movement improves mood and orientation. • Safe mobility lowers risk of discharge to a skilled nursing facility.[46]	• Early mobility order sets ("Up to chair by POD#1").[47] • Johns Hopkins Highest Level of Mobility scale.[48] • PT/OT triggers in EHR for dementia patient.[49] • Gait belts/safe transfer equipment for nursing staff.[50]	• Write mobility into daily orders ("Ambulate TID with assist"). • Remove lines and devices (IVs, Foleys) as soon as clinically safe. • Nurse or aide should walk the patient at least 3x/day (document steps in flowsheet). • Minimize/avoid bed/chair alarms (used sparingly, for safety alerts not restraint).[51] • Reinforce routines (toileting, safe wandering paths) instead of restraints. • Review mobility goals in daily rounds; report progress (e.g., "walked 20 feet with walker"). • Teach the family safe ambulation support to continue at home.
Medication	• Inappropriate antipsychotic or sedative use is common in acute agitation.[52] • High sensitivity to side-effects and interactions can exist. • Antipsychotics and sedatives are often overused for agitation in patients with hyperactive delirium superimposed on dementia.	• Avoiding high-risk medications prevents delirium, falls and mortality. • Pharmacist-led reconciliation reduces errors and readmissions. • Simplified regimens improve safety post-discharge.	• Admission/discharge medication reconciliation forms.[53] • Beers Criteria quick-reference (flag high-risk medications for cognition/mobility).[28] • STOPP/START for geriatric prescribing/deprescribing.[29] • Anticholinergic Burden Calculator (quantify delirium risk load).[30] • EHR alerts for high-risk inpatient medications (e.g., diphenhydramine, benzodiazepines).[54] • Pharmacy consult checklist (daily medication optimization for dementia).[55]	• Reconcile on admission: avoid diphenhydramine, benzodiazepines and sedative-hypnotics. • Deprescribe daily; simplify to the lowest effective regimen. • Use non-drug de-escalation before antipsychotics; if needed, use at lowest dose/for shortest time. • Involve geriatric/pharmacy teams early for complex cases. • Provide the caregiver with a one-page discharge medication list with the "avoid" section circled. • Communicate changes directly to the skilled nursing facility/home health if transferring.

4M Domain	ADRD and the 4Ms	Clinical impact	Clinical tools	Provider actions
What Matters	• Residents may have limited ability to express changing preferences.[56] • Advance care planning discussions are often delayed or generic.	• Aligning routines with lifelong preferences improves mood and engagement. • Documented goals (e.g., hospitalization vs. comfort) prevent unnecessary transfers (e.g., to hospital).	• Serious Illness Conversation Guide.[57] • Preferences for Everyday Living Inventory.[58] • Get to Know Me guide (preferences, history and what matters most).[5] • POLST/MOLST and advance directive forms.[7]	• Use Get to Know Me guide on admission; post 2-3 preferences on care board (e.g., "likes gospel music at breakfast"). • If the patient cannot articulate preferences, involve the caregiver or proxy to honor previously expressed values. • Review preferences quarterly with family at care conference; update EHR.[59] • Ensure care routines reflect preferences around activities of daily living (e.g., eating, dressing, bathing). • Document end-of-life wishes (e.g., comfort-focused care, do-not-hospitalize orders). • Advocate for consistent caregiving staff for residents with ADRD to reduce distress and support familiarity with preferences.
Mentation	• Cognitive impairment may mask new symptoms (e.g., infection, dehydration). • There is a high risk of delirium due to polypharmacy, transitions and infections. • Dementia-related behaviors are common (agitation, wandering, depression, apathy). • Depression often presents atypically (irritability, withdrawal).	• Tailored behavioral support reduces agitation and staff stress. • Early delirium recognition avoids unnecessary hospital transfers.[60] • Treating depression improves engagement in activities and therapy adherence.	• Nursing Home Toolkit for Assessment of Behavioral and Psychological Symptoms of Distress.[61] • Cornell Scale for Depression in Dementia.[13] • PAINAD/Abbey Pain Scale (nonverbal pain).[42] • Brief CAM (detect delirium superimposed on dementia).[14] • Non-pharmacologic toolkits: music therapy, sensory objects, quiet spaces, scent diffusers.[43] • Agitation Treatment Algorithm.[71] • DICE Approach Worksheet to manage behaviors related of ADRD.[62] • essentiALZ® Training and Certification program.[72]	• Staff should document behaviors (time, trigger, response) daily using ABC sheet. • Develop individualized behavior care plans (identify triggers, effective calming strategies). • Use non-drug approaches first for agitation/insomnia (soothing music, activities, snacks, based on personal preferences). • Include psychosocial therapies (e.g., validation, reminiscent therapy). • Investigate/flag sudden changes in mentation within 24 hours (assess for infection, pain, constipation or new medications). • Social worker should check mood monthly using Cornell scale or observation. • Train all staff in ADRD communication (short sentences, calm tone).
Mobility	• Functional decline may be normalized or overlooked in long-term care residents.[63] • Cognitive impairment increases fall risk (forgetting to use aids, unsafe attempts to walk). • Residents may develop gait changes (shuffling, Parkinsonian) or apraxia. • There may be resistance to assistance due to confusion or apathy. • Staff may over-restrict activity, leading to faster decline.	• Daily movement prevents muscle loss, contractures and pressure injuries. • Structured exercise reduces falls and improves mood. • Safe mobility supports dignity and prolongs independence.	• Restorative Nursing Program logs (daily ambulation/exercise).[64] • STEADI toolkit.[65] • Safe wandering paths (unit maps/enclosed courtyards).[66] • Evaluation and management strategies for falls prevention for persons with advanced ADRD in long-term care.[67]	• Write clear mobility plans into daily care orders (e.g., ambulate to meals with one assist). • Staff to ambulate resident daily; document distance/assistance needed. • Reassess mobility after illness/decline with PT/OT. • Address fall risks proactively (toileting schedules, vision/hearing checks, medication review). • Avoid restraints or immobilizing chairs; instead, supervise walking or provide safe paths. • Engage residents in meaningful mobility (e.g., walk to garden, activity room). • Train staff in safe transfer techniques and emphasize maintaining independence. • Do a post-fall huddle: why did it happen, what can we change (lighting, toileting, medication timing)?
Medication	• Residents may be prescribed antipsychotics for behaviors without a full work-up. • Antipsychotics, sedatives and anticholinergics are frequently overused in ADRD.[68] • There is difficulty understanding or reporting side-effects.	• Deprescribing improves alertness, appetite and mobility. • There is less susceptibility to sedation, falls and anticholinergic burden. • Pain control reduces agitation and inappropriate psychiatric medication use. • Optimized medication regimens improve safety and quality of life.	• Monthly consultant pharmacist drug review checklist (federally required).[53] • Beers Criteria (flag high-risk medications for cognition/mobility).[28] • STOPP/START deprescribing protocols.[29] • Antipsychotic ABC behavior logs (required before medication initiation).[62] • Gradual dose reduction monitoring forms/templates.[69] • Pain scales to guide non-psychotropic treatment (avoid unnecessary medications).[42]	• Consultant pharmacist reviews monthly; document action taken (e.g., "Stopped oxybutynin"). • If resident is on an antipsychotic, record behavior logs showing non-pharmacological attempts before tapered continuation. • Treat pain proactively (scheduled acetaminophen) before using psychotropics.[70] • Educate staff on why medications are tapered, comorbidities and side effects; observe for alertness/mood improvements. • Ensure essential medications (e.g., thyroid, B12, cholinesterase inhibitors) are continued if still effective.

PRACTICAL NARRATIVE TOOLS: DEMENTIA CARE JOURNEYS

Applying the 4Ms to dementia care journeys

This section introduces three fictional patient archetypes to illustrate common care journeys for individuals living with ADRD and their care partners. These archetypes are not case studies or clinical vignettes; rather, they are teaching tools to help providers visualize how Age-Friendly care guided by the 4Ms framework can meaningfully change patient outcomes for those living with ADRD and their care partners.

Purpose of the dementia care journeys

- **Bring the 4Ms to life:** By showing both a "non-Age-Friendly" journey and an "Age-Friendly" journey, these tools highlight the real impact of incorporating Age-Friendly 4Ms care (What Matters, Medication, Mentation and Mobility) into dementia care.
- **Support training and education:** Providers can use these archetypes as scripts during staff training, clinical huddles or presentations, offering a relatable way to discuss best practices in dementia-capable and Age-Friendly care.
- **Promote reflection:** These stories are intentionally personal, focusing not only on the individual with ADRD but also on the care partner. This allows providers to reflect on the lived experience of patients and caregivers navigating the health system alongside their loved one.

How to use these tools

- **As a script.** Use the narrative flow in staff education to walk through "what often happens" vs. "what could happen with an Age-Friendly dementia-capable approach."
- **In team training.** Pair the archetypes with the care setting matrices. After presenting the narrative, teams can identify where their own workflows align with or diverge from the ideal Age-Friendly dementia journey.
- **For simulation or role play.** Providers and staff can role-play conversations between archetype patients, care partners and clinicians to practice integrating the 4Ms into dementia care.
- **As a visual aid.** Display the illustrated care journeys alongside the narratives during workshops, PowerPoint presentations or care team meetings to reinforce key takeaways visually and textually.
- **To guide quality improvement.** Teams can use the archetypes as benchmarks, asking: *"Where do we see ourselves in James' or Annette's journey, and what can we change to make our care more Age-Friendly for people living with dementia?"*

Connection to the matrices

Each archetype ties directly to the care setting matrices. As providers review the narrative journeys, they can cross-reference the relevant matrix interventions (e.g., ADRD-specific screening, fall risk assessment, medication review and advance care planning). This makes the archetypes not just storytelling devices, but practical companions to implementing the 4Ms in dementia-capable care.

ARCHETYPE 1

James and Molly

James, a 70-year-old retired accountant with a history of hypertension, mild sleep apnea, chronic arthritis and overactive bladder, begins to show subtle but troubling changes at home. Once meticulous with household bills and routines, he now forgets to pay them, becomes irritable and has occasional word-finding difficulty. Molly, his wife, notices the stove left on and water running unattended.

JAMES AND MOLLY | Current pathway

James, a 70-year-old retired accountant with a history of hypertension, mild sleep apnea, chronic arthritis and overactive bladder, begins to show subtle but troubling changes at home. Once meticulous with household bills and routines, he now forgets to pay them, becomes irritable and has occasional word-finding difficulty. Molly, his wife, notices the stove left on and water running unattended.

Concerned, Molly mentions these changes to his primary care provider during his annual wellness visit. The provider completes a physical exam and notes James' vital signs are stable. His current medication list remains unchanged, including prednisone for his arthritis flare-ups, tolterodine for bladder urgency, lisinopril and a daily multivitamin.

The provider, pressed for time and reassured by James' otherwise healthy appearance, attributes the changes to "normal aging." No labs or cognitive assessment are performed. A brief note is entered and the post-visit summary lacks a follow-up plan or guidance for Molly about what to monitor or when to seek further evaluation.

Over the following months, James becomes increasingly withdrawn and apathetic. He begins missing social gatherings, gets lost while driving to familiar places and struggles to follow recipes he once knew by heart. One afternoon, he slips stepping out of the car and sustains a minor fall. Molly brings him to the emergency room for evaluation.

In the ER, James faces a long overnight wait in a brightly lit, noisy environment. Sleep-deprived and anxious, he becomes confused and agitated. Staff, unfamiliar with his baseline and lacking collateral history, interpret his behavior as aggression and administer sedatives to "help him rest." The medication worsens his confusion and by morning he is delirious, pulling at lines and disoriented to place and time.

Molly is alarmed by the rapid change. She reduces her work hours to stay by his side, and her own health and finances begin to suffer under this strain. No one has yet discussed with her what support is available or how to navigate the next steps in James' care.

JAMES AND MOLLY | Improvement opportunities (4Ms-aligned actions)

Missed opportunity: **No cognitive screening or work-up**

Improvement: Conduct cognitive and depression screening; order labs to rule out reversible causes; document findings in the EHR.

Missed opportunity: **What Matters not discussed**

Improvement: Hold a shared conversation with the patient and caregiver to understand goals, priorities and preferences; document in the care plan and in follow-up visits.

Missed opportunity: **No medication reconciliation; inappropriate sedatives prescribed**

Improvement: Perform a comprehensive medication review using Beers Criteria; avoid or deprescribe sedatives; monitor for side-effects that impair alertness or balance.

Missed opportunity: **Caregiver stress unaddressed**

Improvement: Screen the caregiver for stress or burnout; provide education on ADRD care strategies; connect them to respite and community supports (e.g., Alzheimer's Association, Memory Café).

Missed opportunity: **No fall or mobility assessment**

Improvement: Complete the Timed Up & Go test; assess home safety; refer to physical, occupational and speech-language pathologists for mobility, balance and functional support.

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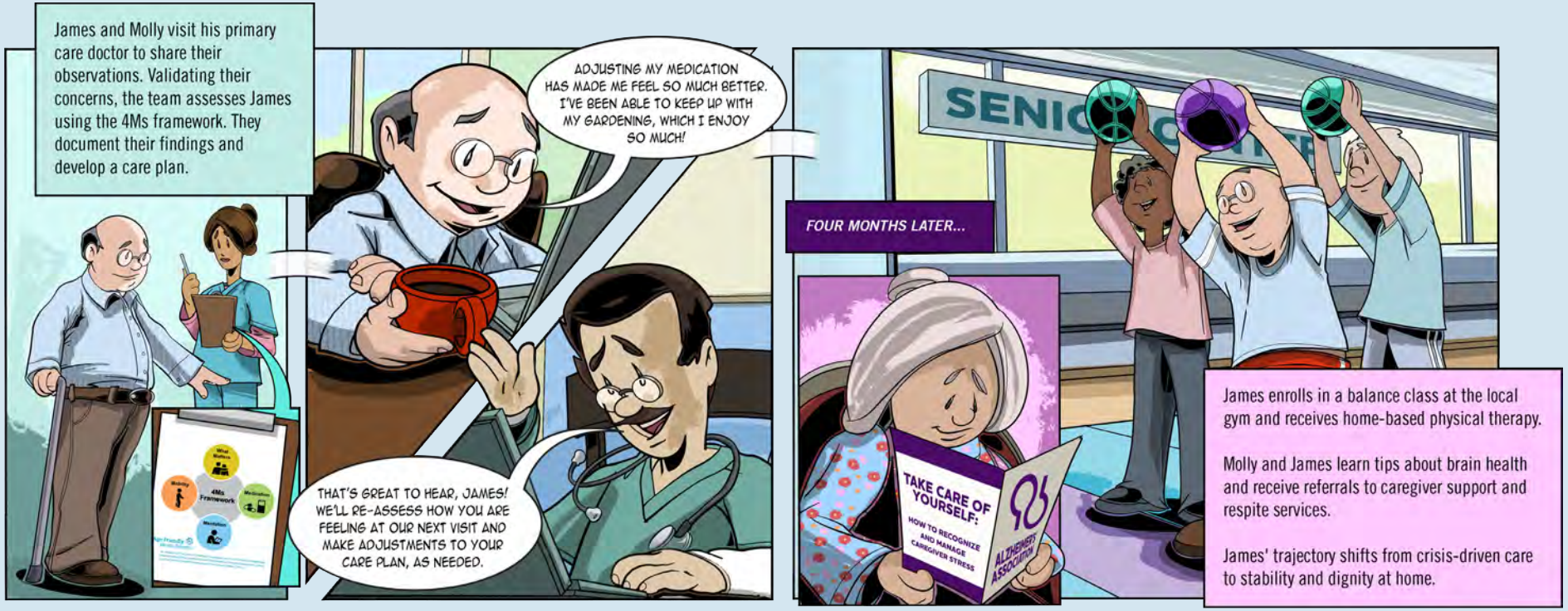
JAMES AND MOLLY | Ideal pathway: 4Ms in action



James, a 70-year-old retired accountant with a history of hypertension, mild sleep apnea, chronic arthritis and overactive bladder, begins to show subtle but troubling changes at home. Once meticulous with household bills and routines, he now forgets to pay them, becomes irritable and has occasional word-finding difficulty. Molly, his wife, notices the stove left on and water running unattended.

Concerned, Molly brings these changes to his primary care provider during his annual wellness visit. The provider pauses, validates her input and conducts a SLUMS. The screen is positive, so the provider orders labs and completes a PHQ-9 to check for depression. A TUG test reveals early balance concerns. The provider reviews James' medications, identifies tolterodine as an anticholinergic and potentially contributing to cognitive or balance changes, and adjusts his regimen in collaboration with pharmacy.

The provider asks James and Molly what matters most. James says he wants to remain independent, garden and continue meeting his friends for coffee. These goals are documented in the care plan. Molly's caregiving role is acknowledged and she receives referrals to local caregiver support and respite services. Before they leave, the nurse provides printed education on mild cognitive impairment, fall prevention and safe driving resources, and ensures a follow-up appointment is scheduled in one month.

Within weeks, a nurse conducts a structured cognitive care planning visit, advance care planning begins and referrals are made for PT, community balance classes and home health care. The office team coordinates with a memory clinic for further evaluation and ensures all documentation is shared with specialists.

James maintains safe mobility and social engagement, and Molly feels supported rather than overwhelmed. By integrating ADRD-specific 4Ms care (early cognitive screening, deprescribing, mobility planning and "What Matters" conversations), James' trajectory shifts from crisis-driven care to stability and dignity at home.

JAMES AND MOLLY | Teaching points

Improvement: **Early cognitive impairment not dismissed**

What was learned: Train PCPs and clinic staff to act on caregiver observations; incorporate brief cognitive evaluations (e.g., AD8) and depression screening at the first sign of cognitive change.

Improvement: **Medication risks identified**

What was learned: Establish pharmacist-led medication reviews for older adults; use Beers Criteria to reduce sedatives and duplicate therapies; create workflows for ongoing medication reconciliation.

Improvement: **Fall risk identified**

What was learned: Integrate routine fall and mobility assessments (e.g., TUG, gait observation) into primary care visits; provide caregiver education on home safety, footwear and assistive devices.

Improvement: **Goals clarified**

What was learned: Use structured tools such as "What Matters to You," "Get to Know Me" or "Goals of Care" forms; document preferences in the EHR so all team members can align care with the patient's priorities.

Improvement: **Caregiver supported**

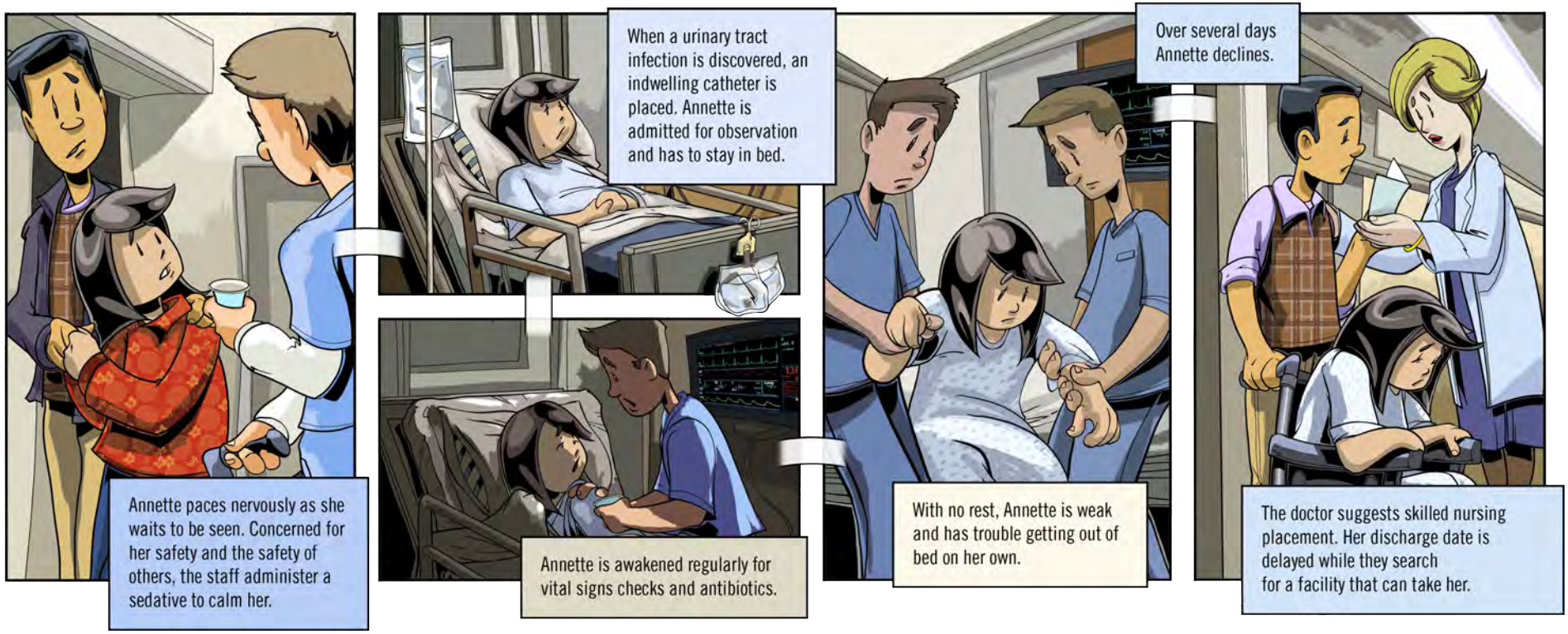
What was learned: Normalize caregiver support as part of the care plan; connect them to community resources (Alzheimer's Association, respite programs, Memory Cafés); ensure follow-up for caregiver wellbeing.

ARCHETYPE 2

Annette and Stephen

Annette, a 67-year-old retired business owner with a history of hypertension, coronary artery disease and strokes begins showing increasing confusion and fatigue at home. Stephen, her son who lives with her, finds her still in her nightgown late in the day, forgetting names and resisting help. He notices this continues for several days. Stephen calls her PCP, who is currently unavailable but directs them to the ER for evaluation.

ANNETTE AND STEPHEN | Current pathway



Annette, a 67-year-old retired business owner with a history of hypertension, coronary artery disease and strokes begins showing increasing confusion and fatigue at home. Stephen, her son who lives with her, finds her still in her nightgown late in the day, forgetting names and resisting help. He notices this continues for several days. Stephen calls her PCP, who is currently unavailable but directs them to the ER for evaluation.

While in the ER, Annette becomes increasingly restless. Staff, concerned for her safety and the safety of others, administer a sedative to calm her. The sedation limits her mobility. When a urinary tract infection is discovered, an indwelling catheter is placed. She is admitted to an inpatient unit for further evaluation given her medical history and ongoing confusion.

In the hospital, her cardiovascular evaluation is negative. Despite this, her hospital stay becomes complicated. Her sleep is frequently interrupted by overnight vital signs checks, alarms and unfamiliar sounds in the shared room. Disoriented and exhausted, she spends most of her time in bed.

Over several days, Annette experiences noticeable functional decline. Prior to hospitalization, she was able to walk independently, but she now needs two staff members to help her stand. Her appetite decreases and PT sessions are repeatedly delayed due to "medical instability." She becomes weaker and less engaged. Repeat blood draws and vital checks cause further distress and confusion, contributing to a cycle of agitation and sedation.

As discharge planning begins, the social worker is actively searching for a skilled nursing placement, but beds are limited. Stephen feels overwhelmed watching his mother's condition spiral. He struggles to understand how a visit to the ER has led to such a decline in his mother's condition.

ANNETTE AND STEPHEN | Improvement opportunities (4Ms-aligned actions)

Missed opportunity: **PCP overlooks concerns, no cognitive or mood screening**

Improvement: Perform cognitive and mood assessments (Nu-Desc, SLUMS, PHQ-9, CAM); order labs or imaging as indicated; document findings to guide diagnosis and follow-up.

Missed opportunity: **What Matters not discussed**

Improvement: Explore the patient's goals and values (independence, daily routines, time with family); incorporate her preferences into care planning and discharge decisions.

Missed opportunity: **Sedative use worsens agitation**

Improvement: Avoid antipsychotics or sedatives unless clinically necessary; address underlying causes of agitation (pain, environment, anxiety); monitor for medication side-effects that impair cognition or mobility.

Missed opportunity: **Caregiver excluded from planning**

Improvement: Engage the caregiver in advance care planning and hospital discharge discussions; provide caregiver education on ADRD communication, medication safety and home supports.

Missed opportunity: **No fall or mobility interventions**

Improvement: Implement early mobilization and PT/OT interventions during hospitalization; assess for fall risk; ensure safe transfer and ambulation practices across care transitions.

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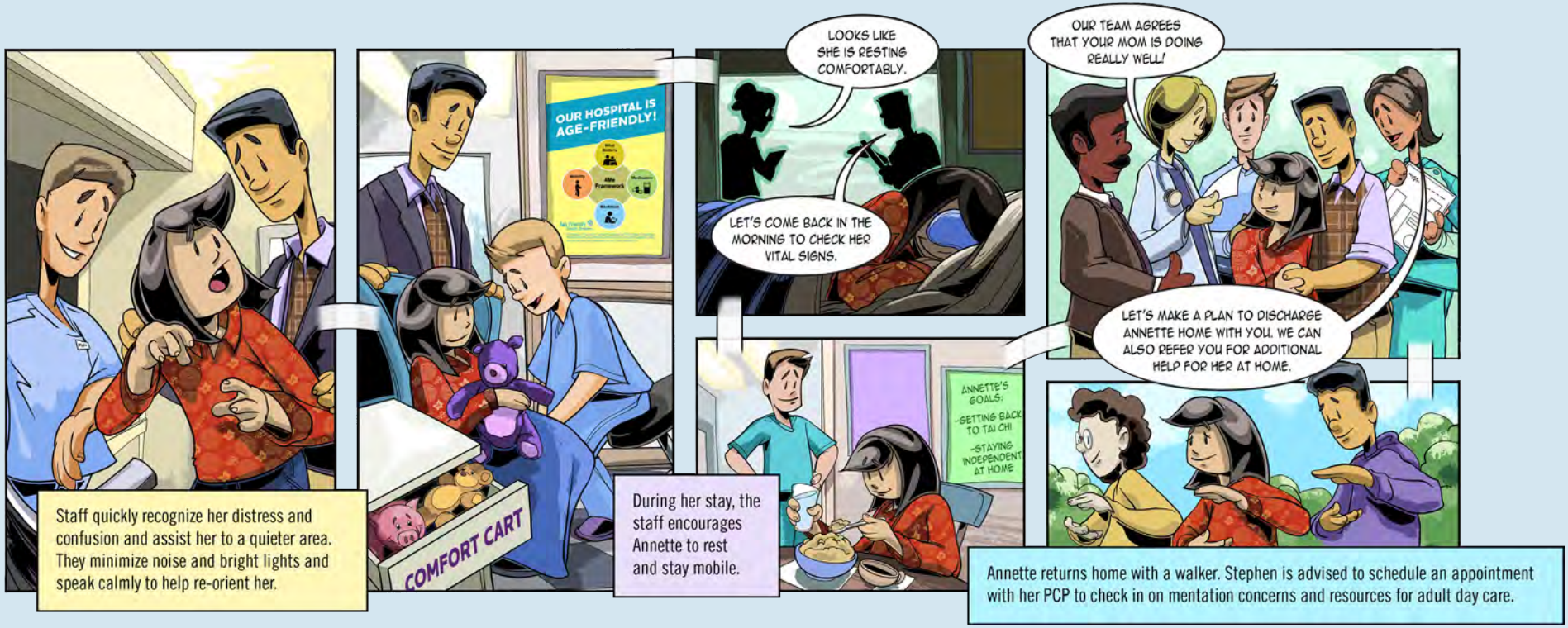
ANNETTE AND STEPHEN | Ideal pathway: 4Ms in action



Annette, a 67-year-old retired business owner with a history of hypertension, coronary artery disease and strokes begins showing increasing confusion and fatigue at home. Stephen, her son who lives with her, finds her still in her nightgown late in the day, forgetting names and resisting help. He notices this continues for several days. Stephen calls her PCP, who is currently unavailable but directs them to the ER for evaluation.

While in the ER, Annette becomes visibly restless, but staff quickly recognize that her behavior reflects distress and confusion rather than agitation. The team minimizes noise and bright lights and speaks calmly to re-orient her. Instead of sedation, they engage her son to provide comfort and reassurance. Stephen validates that Annette does not use assistive devices (e.g., glasses, hearing aids) at home. A dementia-friendly "comfort cart" with a blanket and distraction tools helps settle her.

Annette is admitted to an inpatient room for further evaluation and treatment after a UTI is suspected. Upon arrival, the nurse confirms no indwelling catheter is placed; an external wicking catheter is used. Staff implement a "Sleep-Friendly Hospital" protocol: vital signs checks are performed before bedtime and in the morning, lights are dimmed at night and staff avoid unnecessary overnight disruptions.

Physical and occupational therapy are engaged early. Annette is ambulated at least three times a day, first to sit in a chair for meals, then for short walks in the hallway. Nursing staff reinforce these efforts by documenting mobility milestones. Her What Matters goals, discussed with Stephen, include "getting back to Tai Chi" and "staying independent at home." These guide care decisions, ensuring that therapy and discharge planning align with her personal values.

Interdisciplinary huddles include nursing, PT, case management and pharmacy. Together they identify potential barriers early, including home safety and caregiver needs. The social worker explores discharge options proactively, focusing first on home with supports rather than facility placement. Stephen feels supported and informed, receiving regular updates and practical education on how to help his mother continue her recovery at home.

Annette's infection resolves, her sleep and appetite stabilize, and she regains strength and confidence through daily mobility and engagement. By discharge, she is ambulating with a walker and smiling at the thought of returning to her own home, feeling empowered and respected.

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ANNETTE AND STEPHEN | Teaching points

Improvement: **Early ADRD not dismissed**

What was learned: Train PCPs and hospital clinicians to recognize and act on caregiver concerns; perform cognitive and mood assessments (Nu-Desc, SLUMS, PHQ-9, CAM) early in the care process; ensure findings are documented and shared across transitions.

Improvement: **Medication risks identified**

What was learned: Implement pharmacist-led medication reviews; apply Beers Criteria and reduce the use of sedatives or antipsychotics; use behavioral and environmental strategies to manage agitation or confusion.

Improvement: **Fall risk identified**

What was learned: Incorporate fall and mobility screening into admission and discharge planning; initiate early PT/OT consults; educate caregivers on safe mobility and fall prevention techniques at home.

Improvement: **Goals clarified**

What was learned: Use structured What Matters tools during hospitalization and at follow-up visits; document the patient's goals.

Improvement: **Caregiver support**

What was learned: Include the caregiver in behavioral management in the ER and care planning and discharge discussions inpatient; provide ADRD education, respite resources and caregiver support referrals; ensure ongoing follow-up on caregiver wellbeing.

ARCHETYPE 3

Denise and Latrice

Denise, a 76-year-old widow with a history of hypertension and osteoarthritis, is discharged from the hospital to a short-term rehabilitation facility following hip surgery. Her sister, Latrice, lives in a different state and serves as her healthcare proxy, engaging in her sister's care remotely. Given Denise's ongoing confusion, limited mobility and lack of available family supports at home, the team determines that skilled nursing facility placement is the only safe and reasonable option to support her recovery.

DENISE AND LATRICE | Current pathway

Denise, a 76-year-old widow with a history of hypertension and osteoarthritis, is discharged from the hospital to a short-term rehabilitation facility following hip surgery. Her sister, Latrice, lives in a different state and serves as her healthcare proxy, engaging in her sister's care remotely. Given Denise's ongoing confusion, limited mobility and lack of available family supports at home, the team determines that skilled nursing facility placement is the only safe and reasonable option to support her recovery.

At the facility, Denise's admission process occurs over a weekend and the staff note that her medical history indicates "possible dementia." No cognitive screen is conducted and staff attribute her disorientation to "normal aging."

To manage restlessness, sedating medications are prescribed, leaving her groggy and disengaged. She begins sleeping through most of the day, missing therapy sessions and eating poorly. Meal trays are left in her room without supervision or encouragement, and her weight steadily declines.

Mobility therapy is limited to scheduled physical and occupational therapy sessions. Staff rarely prompt her to walk or assist her to the common area, and Denise often remains in bed or a wheelchair for long periods of time. The lack of movement increases her risk of pressure injuries and functional decline.

Latrice is contacted only for signatures and consent forms. No one asks her about Denise's daily routines, preferences or triggers. Latrice receives no information about delirium, fall prevention or ADRD care, leaving her feeling powerless and disconnected from her sister's care.

DENISE AND LATRICE | Improvement opportunities (4Ms-aligned actions)

Missed opportunity: **No cognitive screening or ADRD work-up**

Improvement: Complete cognitive and depression screening; document results and initiate care plan adjustments for cognitive impairment.

Missed opportunity: **No collection of life history or preferences**

Improvement: Collect life history and preferences using a Get to Know Me Form to better engage and support the resident and their caregiver.

Missed opportunity: **Sedating medications prescribed without review**

Improvement: Review medications using Beers Criteria; deprescribe or reduce sedatives; monitor for side-effects like lethargy, confusion and poor appetite.

Missed opportunity: **Mobility goals not individualized**

Improvement: Integrate mobility into daily routines (walks to meals, activity sessions); schedule PT/OT when the patient is most alert; document proactively.

Missed opportunity: **No structured nutrition or weight monitoring**

Improvement: Add weekly nutrition and weight tracking; involve dining staff and caregivers in strategies to promote eating and hydration.

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DENISE AND LATRICE | Ideal pathway: 4Ms in action

Denise, a 76-year-old widow with a history of hypertension and osteoarthritis, is discharged from the hospital to a short-term rehabilitation facility following hip surgery. Her sister, Latrice, lives in a different state and serves as her healthcare proxy, engaging in her sister's care remotely. Given Denise's ongoing confusion, limited mobility and lack of available family supports at home, the team determines that skilled nursing facility placement is the only safe and reasonable option to support her recovery.

At the facility, Denise's admission begins with a structured intake including cognitive and depression screenings and comprehensive medication reconciliation. Staff schedule an early care conference with Latrice by phone, asking about Denise's routines, history and preferences. They learn she is called "Bit," loves gardening and baking, enjoys sweets and values her independence. This information is documented in her chart and displayed on a "Getting to Know Me" board inside her room, helping all staff connect with her as a person, not just a patient.

Her medications are reviewed using the Beers Criteria and sedatives are reduced. Her pain management plan is carefully adjusted to balance comfort with alertness. Nursing staff are trained to monitor for side-effects and to proactively track her nutrition and weight. Dining staff and aides encourage Denise to eat in the common dining room, where companionship and conversation stimulate her appetite and mood.

Mobility goals are integrated into her daily routine. Staff walk with her to meals and group activities. PT and OT sessions are scheduled at her most alert times of day, and therapy exercises are reinforced during regular care (for example, walking to the bathroom instead of using a bedside commode). Recreation therapy engages her in light gardening tasks in the courtyard, connecting to her interests and sense of purpose.

When Denise asks about her sister, staff use person-centered communication, acknowledging her feelings, offering reassurance and gently redirecting her to meaningful activities. Her room includes orientation cues such as a visible calendar, whiteboard with staff names and family photos, creating a sense of familiarity and calm.

Latrice is invited to join care plan meetings virtually and receives consistent updates from the nursing and therapy teams. Staff provide her with education on delirium recovery, ADRD care and long-term support planning, along with resources for long-distance caregiving. They encourage her to share insights about Denise's preferences and help integrate those into daily routines.

DENISE AND LATRICE | Teaching points

Improvement: **Early ADRD recognized and addressed**

What was learned: Conduct cognitive and depression assessments at SNF admission; adjust care plan accordingly; train staff in ADRD communication strategies.

Improvement: **Medication side-effects identified and reduced**

What was learned: Implement pharmacist or provider-led medication reconciliation; use Beers Criteria; adjust pain or sleep medications to maintain alertness and participation in therapy.

Improvement: **Fall and mobility risk managed proactively**

What was learned: Embed mobility in daily care; walk to meals and group activities; schedule therapy at peak alertness; monitor for functional improvements weekly.

Improvement: **Goals and values incorporated into daily care**

What was learned: Document the patient's goals ("to take care of myself and my plants"); integrate her interests into recreation therapy and meal planning.

Improvement: **Caregiver actively engaged**

What was learned: Schedule virtual care conferences with the caregiver; provide education on ADRD, communication techniques and fall prevention; support caregiver confidence and connection.

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APPENDIX A:
PROVIDER SELF-ASSESSMENT

PROVIDER SELF-ASSESSMENT

PURPOSE: To help individual providers, interdisciplinary teams or departments evaluate how consistently they deliver care aligned with the 4Ms while integrating dementia-capable practices across any care setting.

INSTRUCTIONS: For each statement, check the option that best reflects your current practice.

Scale: 3 = Always | 2 = Sometimes | 1 = Never

WHAT MATTERS

	Always (3)	Sometimes (2)	Never (1)
I ask older adults what matters most to them regarding health goals, routines and preferred daily activities.	☐	☐	☐
I document "What Matters" and make it visible to all team members across care transitions.	☐	☐	☐
I include caregivers or healthcare proxies in goal setting when patients have cognitive impairment.	☐	☐	☐
I adapt care plans to align with the person's life story, sensory preferences and cognitive stage.	☐	☐	☐
I revisit "What Matters" when health status or cognition changes.	☐	☐	☐
Subtotal (out of 15): _____			

MEDICATION

	Always (3)	Sometimes (2)	Never (1)
I review all medications for appropriateness using Beers or STOPP/START criteria.	☐	☐	☐
I assess for cognitive side effects or anticholinergic burden in people living with ADRD.	☐	☐	☐
I avoid or deprescribe sedatives/antipsychotics unless clearly indicated.	☐	☐	☐
I communicate medication changes clearly with caregivers and next providers.	☐	☐	☐
I explore non-drug alternatives for behavioral or sleep issues before prescribing.	☐	☐	☐
Subtotal (out of 15): _____			

MENTATION

	Always (3)	Sometimes (2)	Never (1)
I screen for cognitive change and depression using validated tools (AD8, PHQ-2/9).	☐	☐	☐
I recognize and manage delirium risk factors (pain, infection, dehydration, medications, environment).	☐	☐	☐
I tailor communication to cognitive level (simple sentences, calm tone, orientation cues).	☐	☐	☐
I provide education and community resources to caregivers after identifying cognitive decline.	☐	☐	☐
I coordinate with other clinicians for diagnostic work-up or follow-up on suspected dementia.	☐	☐	☐
Subtotal (out of 15): _____			

MOBILITY

	Always (3)	Sometimes (2)	Never (1)
I assess fall and mobility risk using simple tests (TUG, gait observation) at each visit or shift.	☐	☐	☐
I promote safe movement and independence, even during acute illness or hospitalization.	☐	☐	☐
I address wandering or unsafe ambulation behaviors in people living with ADRD through environmental or staffing solutions.	☐	☐	☐
I involve physical, occupational and speech-language pathologists when functional or cognitive changes affect mobility.	☐	☐	☐
I teach caregivers mobility and fall-prevention techniques for home or community settings.	☐	☐	☐
Subtotal (out of 15): _____			

TOTAL SCORE (out of 60): _____

SCORING MATRIX AND INTERPRETATION

Score range	Performance category	Interpretation	Recommended focus
50+	**Consistently Age-Friendly and dementia-capable**	Practices are well integrated and documented.	Share workflows; mentor peers; pursue formal Age-Friendly Health System or dementia-capable recognition.
38-49	**Solid foundation – targeted improvement needed**	Core practices are in place but inconsistently applied or documented.	Identify lowest-scoring M; refine workflow reliability and handoffs.
25-37	**Developing – inconsistent practice**	Awareness is present but not systematic.	Begin QI cycle: select one M, pilot a standard process, measure improvement.
Less than 25	**Needs improvement**	Age-Friendly and dementia-capable elements are largely absent.	Start with foundational education and a single M (What Matters). Pair with coaching or champion support.

USING THE RESULTS

1. Interpret patterns, not just scores

- Look for your lowest-scoring M – that's your priority focus.
- Aggregate team results quarterly to reveal systemic barriers (e.g., lack of screening prompts).

2. Translate into action

- Less than 25: Start with one M and basic education.
- 25-37: Standardize one reliable workflow.
- 38-49: Strengthen documentation and consistency.
- 50+: Model and spread best practices.

3. Use in QI and learning

- Discuss one domain monthly at huddles.
- Set measurable targets ("Increase cognitive screening to 80% in six months").
- Track correlation with patient outcomes (falls, readmissions, satisfaction).

4. Integrate into training

- Embed in onboarding, annual competencies and cross-disciplinary education.
- Pair with short scenario-based learning on ADRD care communication.

5. Align with organizational goals

- Link low-scoring M's to QI or accreditation projects (e.g., AFHS, Geriatric Emergency Department Accreditation).
- Share high-scoring units in newsletters or recognition programs.

6. Celebrate progress

- Highlight incremental wins ("all caregivers now documented").
- Capture patient and caregiver stories showing 4Ms in action.

APPENDIX B:
DEMENTIA CARE JOURNEYS

ARCHETYPE 1: **James and Molly**

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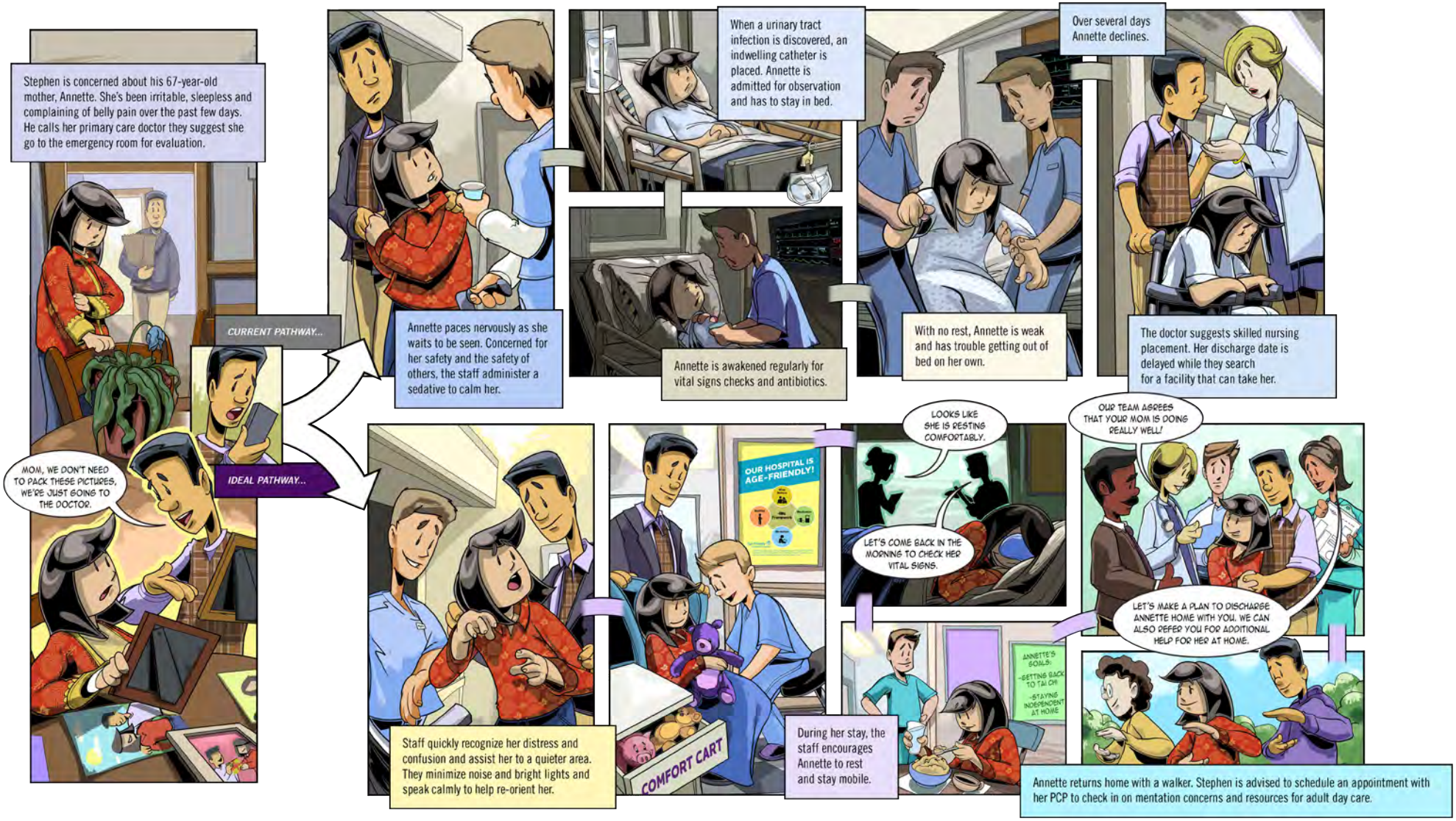
ARCHETYPE 2: **Annette and Stephen**



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ARCHETYPE 3: **Denise and Latrice**

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APPENDIX C:
CLINICAL RESOURCES, TOOLS AND IMPLEMENTATION GUIDANCE

CLINICAL RESOURCES, TOOLS AND IMPLEMENTATION GUIDANCE

The resource numbers correspond to the superscript annotations in the dementia-capable practice matrices on page 6-8.

1. **Alzheimer's Association (2026) 2026 Alzheimer's Disease Facts and Figures.**
   More than 7 million Americans ages 65+ are living with Alzheimer's disease; costs and caregiver burden continue to rise, with billions of unpaid care hours annually. Use these data to justify routine cognitive screening, early What Matters conversations and caregiver resource referrals (e.g., respite, support groups).

2. **Mast, B. T., Molony, S. L., Nicholson, N., et al. (2021) Person-centered assessment of people living with dementia: Review of existing measures.**
   Valid measures exist for values, well-being, "at-homeness" and strengths that support person-centered planning even when verbal abilities decline. Embed preference inventories and caregiver-reported goal tools in intake/healthcare annual wellness visit workflows to hardwire What Matters documentation.

3. **Rahemi, Z., Ozdemir, S., Lei, X., et al. (2022) Advance Care Planning Among Older Adults with Cognitive Impairment.**
   ACP documentation is low among those with dementia/MCI and engagement correlates with fewer burdensome interventions. Trigger ACP prompts at annual wellness visits and during transitions; confirm a healthcare proxy and revisit preferences with significant health changes.

4. **Alzheimer's Association (2025) Get to Know Me.**
   Use this structured template to document life history, likes/dislikes, routines and communication preferences for people with dementia.

5. **The Conversation Project, Institute for Healthcare Improvement (2020) Your Conversation Starter Guide for Caregivers of People with Alzheimer's or Other Forms of Dementia.**
   Use these practical worksheets and prompts to elicit values, routines and preferences directly from people with early dementia and caregivers.

6. **Agency for Healthcare Research and Quality (2023) Patient and Family Engagement in Primary Care.**
   Engagement strategies such as teach-back, clear medication lists and action plans improve safety and satisfaction in cognitively impaired patients. Standardize caregiver involvement in planning and use structured tools to capture expressed goals.

7. **National POLST Collaborative (2025) POLST for Patients.**
   This resource charts clear differences between advance directives (legal documents naming a surrogate and general treatment wishes) and POLST forms (portable medical orders for use when the patient lacks capacity).

8. **Chen, A. T., Chan, K. C. G., Leos, C., et al. (2022) The Use of Visual Methods to Support Communication with Older Adults with Cognitive Impairment: A Scoping Revew.**
   Visual aids (e.g., pictures and icons) significantly enhance comprehension and recall for people with moderate cognitive impairment. Employ visual decision aids and pictorial prompts in ambulatory visits to facilitate meaningful communication.

9. **Zhu, Y., Liu, S., Tardif, S., et al. (2022) Effects of Depression on Changes in Cognitive Function in Older Adults.**
   Depression is linked to accelerated cognitive decline; treating mood symptoms can stabilize cognition and quality of life. Routinely screen with PHQ-2/9, treat as needed and reevaluate cognition post-treatment to avoid misdiagnosis.

10. **Atri, A., Dickerson, B. C., Clevenger, C., et al. (2025) Alzheimer's Association clinical practice guideline for the Diagnostic Evaluation, Testing, Counseling, and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD): Executive summary of recommendations for primary care.**
    This guideline recommends a structured evaluation pathway for early detection: history/informant report, brief screen ⇨ targeted labs ⇨ advanced testing as indicated. Build an office protocol (Mini-Cog ⇨ MoCA/SLUMS; do labs: B12/thyroid-stimulating hormone; screen for obstructive sleep apnea, depression) and refer for neuro/biomarker work-up when appropriate.

11. **Alzheimer's Association (2026). Evidence-based Clinical Practice Guideline on the Use of Cognitive Tests for the Early Detection of Cognitive Impairment in Older Adults in Primary Care.**
    Use brief, freely available cognitive tests (e.g., AD8, SLUMS, etc.) in primary care for adults 55+ to support early detection of cognitive impairment, with recommendations prioritized on clarity, actionability and relevance to real-world clinical decision-making.

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12. **Reisberg, B., Sclan, S. G. (1992) Sequence of functional loss in normal aging and Alzheimer's disease Functional Assessment Staging (FAST) in Alzheimer's Disease: Reliability, Validity, and Ordinality. International Psychogeriatrics, Vol. 4, Issue 3.**

    Functional Assessment Staging is a widely used scale developed by Reisberg and colleagues to describe functional decline in dementia, delineating clear stages from normal aging through severe dementia. Table 1 outlines the progression through these stages with annotations that differentiate normal aging from the patterns seen in dementia.

13. **Interprofessional Comprehensive Geriatric Assessment Toolkit (1998) Cornell Scale for Depression in Dementia.**

    The Cornell Scale for Depression in Dementia is a screening tool designed for use with moderately to severely impaired elderly individuals, combining caregiver interviews and brief patient interviews to rate 19 depressive symptoms based on observations over the prior week, using a 0-2 scale to reflect severity (absent, mild/intermittent, severe). A total score above 10 suggests a probable major depressive episode, while scores above 18 indicate a definite major depressive episode.

14. **Palihnich, K., Gallagher, J., Inouye, S. K., Marcantonio, E. R., Hospital Elder Life Program (2021) The 3D-CAM Training Manual for Research. Version 5.4. Beth Israel Deaconess Medical Center.**

    The 3D-CAM is a rapid, three-minute verbal assessment designed to detect delirium, showing strong accuracy compared to expert evaluations.

15. **American Psychological Association (2011) Zarit Burden Interview.**

    The Zarit Burden Interview is one of the most widely used tools for evaluating the subjective burden perceived by caregivers, particularly those of dementia patients, through a series of items that assess emotional, physical, social and financial impacts of caregiving.

16. **Tang-Wai, D. F., Smith, E. E., Bruneau, M.-A., et al., Alzheimer's Association (November 2020) CCCDTD5 recommendations on early and timely assessment of neurocognitive disorders using cognitive, behavioral, and functional scales.**

    Serial assessments are recommended to confirm diagnosis and monitor progression; follow-up at six- to 12-month intervals is reasonable in primary care when concerns persist. Build a protocol that trends results over time (e.g., Mini-Cog at annual wellness visit; track MoCA/SLUMS trajectories) and pairs cognitive tracking with functional/behavioral measures to trigger timely work-ups or referrals. Use informant input consistently to improve accuracy in ambulatory settings.

17. **de Ruijter, N. S., Schoonbrood, A. M. G., Hoff, E. I., Alzheimer's Association (September 2020) Anosognosia in dementia: A review of current assessment instruments.**

    Anosognosia (impaired insight/judgment) is common in dementia and is linked with reduced therapy compliance and unsafe behaviors; this often presents as resistance to assistive devices (e.g., walkers) and safety recommendations. In ambulatory care, screen insight (e.g., Clinical Insight Rating Scale or Abridged Anosognosia Questionnaire - Dementia), involve caregivers to model device use and use graded trials/visual cues to increase acceptance of mobility aids. Document the insight level so education and safety plans can be tailored and revisited.

18. **National Council on Aging (2023) Evidence-Based Program: A Matter of Balance.**

    Fear of falling is common among older adults with Alzheimer's and can lead to reduced activity, muscle weakness and further fall risk. "A Matter of Balance" is an eight-week, structured group intervention that empowers older adults to view falls as controllable, set realistic activity goals, adapt their environment for safety, and engage in strength and balance exercises. In ambulatory settings, clinicians can refer patients to community MOB programs, provide home safety kits, and collaborate with PT or OT to reinforce mobility confidence and function.

19. **Centers for Disease Control and Prevention (2017) Assessment: Timed Up & Go (TUG).**

    The CDC's TUG tool is a brief, one-minute mobility test in which patients rise from a chair, walk three meters, return and sit down; taking 12 seconds or longer indicates increased fall risk in older adults. The tool also guides observation of gait and balance abnormalities.

20. **Mapi Research Trust (1986) Performance Oriented Mobility Assessment (POMA).**

    POMA, also known as the Tinetti Test, is a validated clinical tool used to evaluate gait and balance in older adults, split into balance and gait sections, scored on a three-point scale, and commonly used to screen fall risk and mobility impairments.

21. **Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2025) STEADI – Older Adult Fall Prevention.**

    The STEADI initiative gives healthcare providers a structured, evidence-based framework — centering on screening, assessment and intervention — along with tools, training and educational resources to prevent falls among older adults.

22. **Alzheimer's Association (2024) Alzheimer's and Dementia Home Safety Tips and Checklist.**

    A structured room-by-room checklist reduces home accident risks by about 30%. Include a printed checklist in the ambulatory packet and refer high-risk patients to occupational therapy for in-home assessment.

23. **MedicAlert Foundation. Safe and Found Services.**

    The MedicAlert Foundation, in partnership with the Alzheimer's Association, offers specialized Safe and Found services, including 24/7 response and medical ID support, to quickly reunite individuals with dementia who wander with their caregivers and families.

24. **American Physical Therapy Association (2023) Mobility and Safety Education for Caregivers.**

    Training caregivers in mobility and safety techniques reduces fall rates by 25% and improves safe transfers for older adults with dementia, even in low-resource settings. Education should include demonstrations of transfer methods, use of mobility aids and fall-prevention strategies tailored to cognitive impairment. Medicare now reimburses for certain caregiver training services (CTS codes), allowing providers to integrate structured caregiver mobility training into care plans without increasing out-of-pocket costs for families.

25. **Olchanski, N., Daly, A. T., Zhu, Y., et al. (April 19, 2023) Alzheimer's disease medication use and adherence patterns by race and ethnicity. *Alzheimer's and Dementia Journal*.**

    Among newly diagnosed ADRD patients, 44% were non-adherent and 24% discontinued therapy within one year; initiation and adherence also varied by socio-demographics. In ambulatory care, simplify regimens (once-daily, combination products), synchronize refills and use pharmacy-prepared blister packs/pill organizers. Build caregiver checks (weekly pillbox review, refill confirmation) and EHR flags for missed refills to trigger outreach.

26. **Pretorius R. W., Gataric, G., Swedlund, S. K., et al., American Academy of Family Physicians (2013) Reducing the Risk of Adverse Drug Events in Older Adults.**

    One in six older adults is hospitalized due to adverse drug events, many preventable via systematic medication reviews, minimizing polypharmacy and simplifying regimens. In ambulatory dementia care, implement regular medication reconciliation, especially after any care transition, and use tools like Beers, STOPP/START criteria to identify high-risk medications.

27. **Agency for Healthcare Research and Quality (2024) Medicine Review Form in AHRQ Health Literacy Universal Precautions Toolkit (3rd ed., Tool #8: Conduct Brown Bag Medicine Reviews).**

    The Medicine Review Form (pages 158-159) provides a structured checklist to document patients' brought-in medications, including prescription, over-the-counter and supplements; assess medication use accuracy; and flag potential safety issues during a brown bag medicine review.

28. **AGS Beers Criteria Update Expert Panel (2023) Updated AGS Beers Criteria® for potentially inappropriate medication use in older adults.**

    Many older adults with dementia in outpatient care are prescribed Beers-listed medications, which are associated with increased risk of delirium, falls and functional decline. In ambulatory settings, review all medications at least annually (and after any change in condition), flag high-risk medications such as anticholinergics and sedatives, and work with patients and caregivers to substitute safer alternatives when possible.

29. **O'Mahony, D., O'Sullivan, D., Byrne, S., O'Connor, M. N., Ryan, C., and Gallagher, P. F., (2015) STOPP/START criteria for potentially inappropriate prescribing in older people: Version 2.**

    Table 1 in this article presents the full list of Screening Tool of Older Persons' Prescriptions and Screening Tool to Alert to Right Treatment Version 2 criteria, providing guidance on medications that should be stopped or started in older adults to reduce potentially inappropriate prescribing.

30. **King, R., Rabino, S. (2024) Anticholinergic Burden Calculator.**

    The ACB calculator is an online tool that combines the Anticholinergic Cognitive Burden Scale and the German Anticholinergic Burden Score to compute a patient's total anticholinergic burden; a score of 3 or higher suggests elevated risk for confusion, falls, cognitive impairment and mortality in older adults.

31. **Mohan, A., Riley, M. B., Boyington, D., Kripalani, S. (2012) PictureRx: Illustrated medication instructions for patients with limited health literacy. *Journal of the American Pharmacists Association*.**

    Figure 1 in this article illustrates the PictureRx tool's provider-facing medication card, depicting a patient's complete regimen with simplified icons, timing cues and bilingual instructions that enhance comprehension among individuals with limited health literacy.

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32. **Nash, M., Swantek, S. (2018) Neuropsychiatric symptoms of dementia: Monotherapy, or combination therapy? *Current Psychology*, Vol. 17, No. 7.**

    This article equips providers with evidence-based guidance for treating neuropsychiatric symptoms in dementia, discussing the relative benefits and risks of cholinesterase inhibitors alone, memantine alone and the combination of both, highlighting moderate advantages of combination therapy over monotherapy in moderate to severe cases.

33. **Ng, A. W. Y., Chan, A. H. S., Ho, V. W. S., et al. (June 28, 2016) Comprehension by older people of medication information with or without supplementary pharmaceutical pictograms. *Applied Ergonomics*.**

    Adding pharmaceutical pictograms to text labels significantly improves medication comprehension among older adults, especially those with lower education levels. In ambulatory care, provide medication handouts with pictogram-supported instructions — i.e., icons indicating "morning," "after meal" or "take with food" — and verify understanding through teach-back, especially when working with patients experiencing cognitive impairment.

34. **Fong, T. G., Inouye, S. K. (Aug. 26, 2022) The inter-relationship between delirium and dementia: The importance of delirium prevention. *Nature Reviews Neurology*.**

    Inpatients with dementia have markedly higher rates of hospital delirium, which accelerates functional and cognitive decline. On admission, trigger a delirium prevention bundle (orientation cues, sleep protection, hydration, vision/hearing optimization) for any patient with known cognitive impairment. Build daily Confusion Assessment Method checks into RN flowsheets and MD progress notes.

35. **Williams, K. N., Lepore, M., Pillemer, K., et al. (Aug. 8, 2023) Characteristics of elderspeak communication in hospital dementia care: Findings from the Nurse Talk observational study. *International Journal of Nursing Studies*.**

    Simplify language without infantilizing, avoiding "elderspeak," which increases resistance and agitation. Standardize use of name/eye contact, short phrases, concrete choices and cueing. Post bedside "communication tips" and add a whiteboard section for "How to talk with me."

36. **Honinx, E., Van den Block, L., Pivodic, L., et al. (April 2021) Potentially Inappropriate Treatments at the End of Life in Older People With Severe Cognitive Impairment. *Journal of Pain and Symptom Management*, Vol. 61, No. 4.**

    Near end of life, patients with severe cognitive impairment frequently receive burdensome low-value interventions. Embed a goals-of-care timeout for patients with advanced dementia at admission and during clinical deterioration; default to comfort-focused pathways when aligned with preferences. Use a palliative consult trigger (e.g., dementia with recurrent hospitalizations or weight loss).

37. **Montefiore Hudson Valley Collaborative (2024) Implementation Toolkit: What Matters to You? Ask What Matters. Listen to What Matters. Do What Matters.**

    On page 57 of the WMTY Implementation Toolkit, the WMTY Action Tools are featured among key practical resources, posters, training materials and case studies designed to help providers and organizations implement the "What Matters to You?" question into everyday care practices, especially hospitals.

38. **Wang, Y., Yue, J.-R., Xie, D.-M., et al. (Oct. 21, 2019) Effect of the Tailored, Family-Involved Hospital Elder Life Program on Postoperative Delirium and Function in Older Adults: A Randomized Clinical Trial. *JAMA Internal Medicine*, Vol. 80, No. 1.**

    A family-involved version of HELP reduced postoperative delirium, maintained/improved physical and cognitive function and was associated with a shorter hospital stay. For dementia inpatients, implement a family-partnered delirium bundle: train caregivers to assist with orientation cues, mobilization, hydration/nutrition, sleep protection and sensory aids; schedule caregiver huddles at admission and pre-discharge; and add the caregiver to the EMR care team with documented reorientation strategies.

39. **Rodakowski, J., Rocco, P. B., Ortiz, M., et al. (Aug. 1, 2018) Caregiver Integration during Discharge Planning of Older Adults to Reduce Resource Utilization: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Journal of the American Geriatrics Society*.**

    Integrating informal caregivers into admission and discharge planning reduced readmissions by 25% at 90 days and 24% at 180 days and shortened rehospitalization time and costs. In practice, identify the primary caregiver on admission, include them in all major care discussions, and document patient goals and preferences (and caregiver role) as a visible alert in the chart and on the bedside communication board.

40. **Fong, T. G., Inouye, S. K. (Aug. 16, 2022) The inter-relationship between delirium and dementia: The importance of delirium prevention. *Nature Reviews Neurology*.**

    Dementia is the strongest predisposing factor for delirium; common hospital triggers include infection, initiation of central nervous system-active medications, sleep disruption, dehydration and uncorrected sensory loss. Implement a non-pharmacologic prevention bundle on admission (orientation cues, sleep protection, hydration/nutrition, vision/hearing support, early mobility) and perform daily CAM screening to detect changes early.

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41. **Marcantonio, E. R. (Oct. 12, 2017) Delirium in Hospitalized Older Adults. *New England Journal of Medicine*.**

Delirium doubles mortality, prolongs LOS by several days and increases post-acute institutionalization. Use a standard work-up/order set (reversible causes, deliriogenic medication review), prioritize non-drug management (sleep protection, sensory aids, early mobility) and document daily CAM with a plan to return to baseline.

42. **Horgas, A. L. (2018) Assessing Pain in Older Adults with Dementia. The Hartford Institute for Geriatric Nursing, New York University Rory Meyers College of Nursing and the Alzheimer's Association.**

This two-page "Try This Dementia" brief gives providers best practice guidance on assessing pain in older adults with dementia, including recommendations to use self-reporting when possible, validated observational tools like PAINAD and MOBID-2 and caregiver input to ensure comprehensive, accurate pain evaluation.

43. **Hshieh, T. T., Yue, J., Oh, E., et al. (2018) Hospital Elder Life Program: Systematic Review and Meta-analysis of Effectiveness. *The American Journal of Geriatric Psychiatry*.**

HELP reduces delirium by ~40% and lowers fall rates. Implement a bundle at admission: orientation cues, protected sleep (quiet hours, clustered care, no 2 a.m. vitals unless needed), early mobility, hydration/nutrition and vision/hearing optimization. Track nursing checklist compliance each shift.

44. **Angel, C., Brooks, K., Fourie, J. (Sept. 9, 2016) Standardizing Management of Adults with Delirium Hospitalized on Medical-Surgical Units. *The Permanente Journal*.**

A sufficient script recommended in this article is: *"Hi, Mr./Mrs. (name). What a shame you wound up in the hospital because you (diagnosis). Your doctor says you're better and you might be going home tomorrow. I am your nurse and my name is (name), and I'll be taking care of you until (time) today."*

45. **Chen, Y., Almirall-Sánchez, A., Mockler, D., Adrion, E., Domínguez-Vivero, C., Romero-Ortuño, R. (Feb. 10, 2022) Hospital-associated deconditioning: Not only physical, but also cognitive. *The American Journal of Geriatric Psychiatry*.**

Hospital-associated deconditioning is a common, multifaceted syndrome in older adults that affects not only physical function but also cognition, mood and social engagement, with significant negative consequences for recovery and independence. To help prevent deconditioning, providers should implement early mobilization, cognitive stimulation and person-centered care plans that actively engage patients throughout hospitalization.

46. **Knox, S., Downer, B., Haas, A., Ottenbacher, K. J. (July 22, 2021). Mobility and Self-Care are Associated With Discharge to Community After Home Health for People With Dementia. *Journal of the American Medical Directors Association*.**

Among Medicare beneficiaries receiving home health services, those with dementia have lower odds of successfully being discharged to and staying in the community, defined as avoiding readmission or death within 30 days, largely influenced by their levels of mobility and self-care ability. To support patients in avoiding institutionalization, providers should prioritize interventions that enhance mobility and promote independence in self-care during and after home health visits.

47. **Agency for Healthcare Research and Quality, 2017. The Four Es of Early Mobility: Facilitator Guide.**

This facilitator guide introduces the TRIP model's "Four Es" (Engage, Educate, Execute and Evaluate) as a structured approach to implementing early mobility practice; includes process maps.

48. **Johns Hopkins Medicine, Physical Medicine and Rehabilitation, Activity and Mobility Promotion (JH-AMP). Common Mobility Language Guide and Toolkit.**

The JH-AMP toolkit provides standardized mobility assessment and goal-setting tools, such as the Johns Hopkins Highest Level of Mobility scale and Mobility Goal Calculator. These tools can be especially valuable in dementia care by promoting safe daily movement, reducing hospital-associated deconditioning and supporting independence through consistent, team-based mobility practices.

49. **Southerland, L. T., Presley, C. J., Hunold, K. M., Caterino, J. M., Collins, C. E., Walker, D. M. (Dec. 1, 2022) Barriers to and Recommendations for Integrating the Age-Friendly 4-Ms Framework into Electronic Health Records. *Journal of the American Geriatrics Society*.**

Tables 2 and 3 in this article outline recommended EHR triggers for dementia care (i.e., including dementia banners linked to care plans, delirium and falls screening order-sets and high-risk medication alerts) and suggest enhancements such as a single location for retrieving dementia screening and functional assessments, flowsheets integrating cognitive tests (e.g., MoCA, mini-Cog), and age-specific alert parameters to better support documentation and recognition of patients living with ADRD.

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50. **Palese, A., Longhini, J., Businarolo, A., Piccin, T., Pitacco, G., Bicego, L. (Dec. 3, 2021) Between Restrictive and Supportive Devices in the Context of Physical Restraints: Findings from a Large Mixed-Method Study Design. *International Journal of Environmental Research and Public Health*.**

    Restrictive devices (e.g., bed rails, pelvic belts, tightly fastened lap belts) are disproportionately used for patients with ADRD, often out of concern for falls or wandering. Supportive devices (e.g., gait belts, postural chairs, positioning pillows, lap buddies) can better promote safety, upright posture and independence. Critically evaluate device choice and prioritize supportive tools and mobility aids before resorting to restrictive measures, ensuring that interventions enhance rather than limit patient function.

51. **Staggs, V. S., Turner, K., Potter, C., Cramer, E., Dunton, N., Mion, L. C., Shorr, R. (June 9, 2020) Unit-level variation in bed alarm use in U.S. hospitals. *Research in Nursing and Health*.**

    For patients with ADRD, bed and chair alarms effectively act as restraints, limiting mobility and often worsening agitation, confusion and fall risk. Avoid reliance on alarms and instead use supportive alternatives such as purposeful rounding, gait belts, mobility aides, environmental modifications, and 1:1 observation when necessary to promote safety and dignity.

52. **McDermott, C. L., Gruenewald, D. A. (Jan. 22, 2019) Pharmacologic Management of Agitation in Patients with Dementia. *Current Geriatrics Reports*.**

    When dealing with behavioral and psychological symptoms of dementia, use a tiered approach. Start by thoroughly assessing and addressing pain, sensory deficits, medication side-effects, new illnesses or environmental triggers, and implement non-pharmacological strategies such as music therapy, structured routines, communication training and physical activity. If those fail, carefully proceed with pharmacologic options, tailored to symptom type, with low- to moderate-quality evidence supporting combined use of antidepressants, antipsychotics or anticonvulsants alongside cholinesterase inhibitors to manage agitation, depression, psychosis or mood issues.

53. **University of California San Francisco. Hospitalist Handbook, Admission and discharge checklist for hospitalized elders.**

    This checklist highlights practical steps for safe elder care, with a strong emphasis on medication reconciliation at both admission and discharge as an essential process to reduce adverse drug events; providers can use the checklist as an example and adapt it within their own clinical settings to strengthen age-friendly practices.

54. **Saxena, S., Meldon, S. W., Hashmi, A. Z., Muir, M., Ruwe, J. (July 2023) Use of the electronic medical record to screen for high-risk geriatric patients in the emergency department. *JAMIA Open*. Vol. 6, Issue 2.**

    EMR-based best practice alerts can efficiently flag high-risk older adults using criteria such as age ≥ 80, dementia diagnosis, polypharmacy, recent falls or frequent ED visits. Providers can adapt these alerts to their own systems to trigger timely geriatric consults, medication review and early mobility interventions.

55. **Auburn University Harrison College of Pharmacy (2024) Medication Education for Dementia Support (MEDS) Toolkit (pp. 24-25).**

    This MEDS Toolkit includes practical pharmacy consultation checklists: one for documenting and reporting medication-related interventions, such as potential drug interactions, adherence issues or recommendations to prescribers, and another structured referral form for home health or aging services teams to specify the needs of older adults living with dementia and request services like comprehensive or targeted medication reviews, reconciliation or adherence support.

56. **Alzheimer Society of Canada (2019) Conversations About Decision-Making: Respecting Individual Choice.**

    As dementia progresses, individuals' decision-making abilities fluctuate and diminish, affecting their capacity to understand information, weigh consequences and express preferences. Actively engage residents early on, use supportive communication strategies and revisit preferences frequently to ensure care remains aligned with their values.

57. **Berry, C.E., Montgomery, S.H., Santulli R., Cullinan, A. (2024) Adapting the Serious Illness Conversation Guide for Dementia Care. *American Journal of Hospice & Palliative Medicine*.**

    The Serious Illness Conversation Guide is a validated, clinician-facing tool developed with input from both patients and clinicians to support advance care planning discussions. The SICG-D is an adapted version tailored for dementia care. It builds on the strengths of the original SICG to promote values-based advance care planning while enhancing triadic communication among the patient, caregiver and clinician.

58. **Preference Based Living. Preferences for Everyday Living Inventory questionnaires.**

    The PELI offers four adaptable tools to assess older adults' preferences: the Full Nursing Home Version (72 questions) for comprehensive insight; the MDS-linked Short Version (16 key items) for streamlined use; the Rainbow PELI, tailored specifically for LGBTQ+

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residents; and the "Top 10" PELI, a concise questionnaire ideal when time is limited. Providers can choose the version that best fits their residents' needs, care setting and available time.

59. **Zhang, H., Wang, N., Bai, N., Yin, M., (2024) Conducting family meetings on families with dementia: An integrative review.**

    For residents with dementia, structured family meetings help clarify care goals, improve communication and reduce conflict between staff and families. Incorporating regular family meetings into care planning can strengthen trust, align treatment decisions with family expectations and support collaborative dementia care.

60. **Powell, K. R., Isnainy, M., Amewudah, P., Paez-Perez, D., Lee, S., Mehr, D. R., Alexander, G. L., Popescu, M. (Oct. 6, 2024) Untangling the complex web of avoidable nursing home-to-hospital transfers of residents with dementia. *Alzheimer's & Dementia*.**

    Residents with ADRD have a 1.22 times higher likelihood of experiencing avoidable transfers to hospitals, often driven by unclear documentation of "what matters" and limited nursing home resources. Prioritize early, clear discussions and documentation of resident and family care preferences and advocate for stronger staffing and support to prevent unnecessary hospitalizations.

61. **Nursing Home Toolkit. Assessment of Behavioral and Psychological Symptoms of Distress.**

    Use multiple standardized scales tailored to different domains of behavior: general behavior, agitation, apathy, aggression, sleep and wandering. Select and apply domain-specific instruments (e.g., agitation scales, apathy scales, wandering scales) to quantify symptoms, guide interventions and monitor changes over time.

62. **Kales, H. C., Gitlin, L. N., Lyketsos, C. G. (2014) The DICE Approach Worksheet. A practical framework for managing the behavioral and psychological symptoms of dementia.**

    The DICE approach helps caregivers and clinicians manage dementia-related behaviors through four steps: describe, investigate, create and evaluate. It promotes understanding the cause of behaviors and developing person-centered, nonpharmacologic interventions.

63. **Browne, B., Kupeli, N., Moore, K. J., Sampson, E. L., Davies, N. (June 17, 2021) Defining end of life in dementia: A systematic review. *Palliative Medicine*.**

    Functional decline in dementia is often treated as a natural or expected part of aging, which means it may be normalized or overlooked in long-term care residents. Avoid relying on functional decline alone to signal late-stage dementia and instead use a holistic approach that considers medical, psychosocial and palliative needs when planning care.

64. **American Association of Post-Acute Care Nursing (2024) Guide to Restorative Programs (Interactive PDF manual).**

    This guide includes restorative nursing logs, which are structured forms used to record residents' daily restorative interventions such as range of motion exercises, mobility practice and toileting programs. The logs capture details including time spent, staff initials, progress and frequency, supporting accurate documentation and consistency in restorative nursing programs.

65. **Centers for Disease Control and Prevention. STEADI Toolkit.**

    The CDC developed the Stopping Elderly Accidents, Deaths, and Injuries initiative for healthcare providers who care for older adults at risk of falling or with a history of falls. The initiative offers both patient education materials and clinician resources centered on three core elements: screen, assess and intervene.

66. **Tilly, J., Reed, P., Office of Supportive and Caregiver Services, Administration on Aging, Administration for Community Living (May 2015) Responding to the Wandering and Exit-seeking Behaviors of People with Dementia.**

    Design safe wandering paths that are uncluttered, looped and include engaging sights and resting spots to channel wandering into purposeful movement, reduce agitation and support mobility. In nursing homes, these paths can be adapted by incorporating familiar visual cues, benches, sensory features and clear signage to create a secure and calming environment that respects resident autonomy.

67. **Metzger, E. D., Racine, A. M., Inouye, S. K. (Dec. 28, 2017) Advanced Dementia in Long-Term Care: Avoiding the Pitfalls of Fall Prevention, Table 1. *American Journal of Geriatric Psychiatry*.**

    Reframe fall prevention in advanced dementia as comfort-focused care. Use strategies such as environmental adjustments, staff supervision and palliative approaches, avoiding restraints, alarms and sedating medications that can worsen distress or function.

68. **Wang, J., Shen, J. Y., Conwell, Y., Yu, F., Nathan, K., Heffner, K. L., Li, Y., Caprio, T. V. (Sept. 6, 2023) Antipsychotic use among older patients with dementia receiving home health care services: Prevalence, predictors, and outcomes. *Journal of the American Geriatrics Society*.**

    Residents with dementia are significantly more likely to be prescribed antipsychotics and this use is associated with reduced functional improvement over time. Reassess the need for these medications regularly, deprescribe when appropriate and prioritize nonpharmacologic approaches to maintain function and quality of life.

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69. **Mathew, R., Butler, B., Hobbs, D. (October 2016) An Electronic Template to Improve Psychotropic Medication Review and Gradual Dose-Reduction Documentation. *Federal Practitioner*.**

    Electronic documentation templates can improve psychotropic medication reviews and support gradual dose-reduction efforts in long-term care. Use of these tools has been shown to raise documentation rates for medication reviews from 52% to 80% and to increase consistent documentation of dose-reduction attempts, promoting safer prescribing for residents with dementia.

70. **Chibnall, J. T., Tait, R. C., Harman, B., Luebbert, R. A. (November 2005) Effect of acetaminophen on behavior, well-being, and psychotropic medication use in nursing home residents with moderate-to-severe dementia. *American Journal of Geriatric Psychiatry*.**

    Residents with moderate to severe dementia spent more time engaging in social interaction, activities and media, and less time confined to rooms when given scheduled acetaminophen compared to placebo. Consider routinely assessing and treating pain with scheduled acetaminophen to increase resident engagement and potentially reduce agitation in dementia care settings.

71. **Cummings, J., Sano, M., Auer, S., Bergh, S., Fischer, C. E., Gerritsen, D., Grossberg, G., Ismail, Z., Lanctôt, K., Lapid, M. I., Mintzer, J., Palm, R., Rosenberg, P. B., Splaine, M., Zhong, K., Zhu, C. W. (March 6, 2023) Reduction and Prevention of Agitation in Persons with Neurocognitive Disorders: An International Psychogeriatric Association Consensus Algorithm, Figure 2. *International Psychogeriatrics*.**

    Figure 2 presents the IPA Agitation Treatment Algorithm, which outlines a stepwise approach beginning with psychosocial interventions and advancing to pharmacologic strategies as needed based on the severity and characteristics of agitation in individuals with cognitive impairment. The algorithm emphasizes continuous reassessment and personalization of care, integrating nonpharmacologic approaches throughout all stages to reduce recurrence and improve safety across care settings.

    Note: Rexulti (brexpiprazole) has recently been approved for the treatment of agitation associated with dementia due to Alzheimer's disease and can be incorporated as a pharmacologic option within the IPA Agitation Treatment Algorithm (Cummings et al., 2023) when nonpharmacologic interventions are insufficient and pharmacologic treatment is clinically indicated.

72. **Alzheimer's Association (2026). essentiALZ® — Alzheimer's Association Training and Certification.**

    The essentiALZ® Training Program and Certification is a self-paced, three-hour online dementia care training based on evidence-based, person-centered best practices that educates professional care providers on Alzheimer's and dementia care and includes interactive content and continuing education credit. Completing the training and passing its certification exam demonstrates knowledge of quality dementia care practices, awards a certification valid for two years and helps care professionals and organizations enhance person-centered dementia care in long-term and community-based settings.

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